

Appendix A. Effective July 1, 2013 through June 30, 2015

**All benefits in this Appendix are effective July 1, 2013, unless otherwise noted.
Prior Appendix A benefit levels apply to all services received through June 30, 2013.**

Section 1. SUMMARY OF BENEFITS

The State shall maintain a program of benefits that shall include health, dental, vision, and life coverage. The health plan shall include medical, prescription and behavioral health coverage. Any and all services covered by the Plan must be medically necessary as determined by the Plan.

Eligible dependents of members shall have available benefits. All dependents enrolled in the Plan must be enrolled in the same health and dental plan as the member.

Section 2. CONTRIBUTION AMOUNTS

- 1) The salary thresholds will be adjusted annually prior to the benefit choice period to reflect the lower of the increase in the Consumer Price Index from the most recent monthly wage report available or the cost of living adjustments effective on July 1 to wages included in this Agreement. The employee's salary on April 1 shall govern for the next fiscal year. The mid-point for each salary band on May 1 shall govern for the next fiscal year.
- 2) The member shall pay the appropriate dependent premium for the plan that is selected.

Employee Contributions for the Quality Care Health Plan (QCHP)

- 1) Employees enrolled in the QCHP with salaries of \$30,200 or less per year shall pay \$93.00 per month for health plan coverage. Employees with salaries of \$30,201 but not more than \$45,600 per year shall pay \$111.00 per month for coverage. Employees with salaries of \$45,601 but not more than \$60,700 shall pay \$127.00 per month for coverage. Employees with salaries of \$60,701 but not more than \$75,900 shall pay \$144.00 per month for coverage. Employees with salaries of \$75,901 but not more than \$100,000 shall pay \$162.00 per month for coverage. Employees with salaries of \$100,001 or more shall pay \$211.00 per month for coverage.
Effective July 1, 2014, the amount of the contribution shall be adjusted to reflect any changes to the midpoint salary in each of the established brackets.
- 2) Member contributions for dependent coverage shall be \$249.00 per month for one non-Medicare dependent, \$287.00 per month for two or more non-Medicare dependents, \$142.00 per month for one Medicare primary dependents and \$203.00 per month for two or more Medicare primary dependents.
- 3) Employees on leave of absence may be responsible for additional costs as enumerated in the State of Illinois Employee Benefits Handbook.

Employee Contributions for the Managed Care Health Plans (MCHP)

- 1) Employees enrolled in the MCHP with salaries of \$30,200 or less per year shall pay \$68.00 per month for health plan coverage. Employees with salaries of \$30,201 but not more than \$45,600 per year shall pay \$86.00 per month for coverage. Employees with salaries of \$45,601 but not more than \$60,700 shall pay \$103.00 per month for coverage. Employees with salaries of \$60,701 but not more than \$75,900 shall pay \$119.00 per month for coverage. Employees with salaries of \$75,901 but not more than \$100,000 shall pay \$137.00 per month for coverage. Employees with salaries of \$100,001 or more shall pay \$186.00 per month for coverage.

Effective July 1, 2014, the amount of the contribution shall be adjusted to reflect any changes to the midpoint salary in each of the established brackets.

- 2) Member contributions for dependent coverage shall be the weighted average of \$113.00 per month for one non-Medicare dependent, \$159.00 per month for two or more non-Medicare dependents, the weighted average of \$89.91 per month for one Medicare primary dependents and \$126.00 per month for two or more Medicare primary dependents.
- 3) Employees on leave of absence may be responsible for additional costs as enumerated in the State of Illinois Employee Benefits Handbook.

Dental Contributions for the Quality Care Dental Plan (QCDP)

- 1) Employees who elect to participate in the QCDP shall be required to pay \$11.00 per month for such coverage.
- 2) Employees who have one dependent enrolled in a health plan offered pursuant to the State Employees Group Insurance Act of 1971 may cover that dependent in the QCDP, for a contribution of \$6.00 per month. This amount shall be in addition to the amount required for the employee.
- 3) Employees who have two or more dependents enrolled in a health plan offered pursuant to the State Employees Group Insurance Act of 1971 may cover those dependents under the QCDP for a contribution of 8.50 per month. This amount shall be in addition to the amount required for the employee.
- 4) Employees on leave of absence may be responsible for additional costs as enumerated in the State of Illinois Employee Benefits Handbook.

Section 3. HEALTH PLAN COVERAGE

THE QUALITY CARE HEALTH PLAN (QCHP)

- 1) The State shall continue to offer enrollment in the QCHP for members who wish to choose any physician or hospital for services.

- 2) With the exception of certain preventive benefits outlined in this appendix or exempted from copayments pursuant to state or federal law, all eligible services shall be subject to deductibles, co-payments, coinsurance amounts, out-of-pocket maximums, and plan provisions.
- 3) Members who choose to receive services from a provider within the QCHP Provider Network shall receive an enhanced benefit.
- 4) Eligible services not received from a provider within the QCHP Network shall be subject to Maximum Reimbursable Charge (MRC) review and adjustment in addition to deductibles, co-payments, coinsurance amounts and out-of-pocket maximums.

A. Plan Year Deductibles

- 1) Member Plan Year Deductible
 - a. The deductible shall be \$350.00 per fiscal year for employees with annual salaries of \$59,300 or less; \$450.00 per fiscal year for employees with salaries from \$59,301 to \$74,300; and \$500.00 per fiscal year for employees with salaries of \$74,301 or more.
 - b. The employee's salary on April 1 shall govern for the next fiscal year.
 - c. Effective July 1, 2014, these amounts shall increase by \$25.00, for total plan year deductibles of \$375.00, \$475.00 and \$525.00, respectively.
- 2) Dependent Plan Year Deductible
 - a. The deductible for dependents shall be \$350.00
 - b. Effective July 1, 2014, this amount shall increase by \$25.00 for a total plan year deductible of \$375.00.
- 3) Family Plan Year Deductible

The deductible for a family unit shall be limited to two and one-half times the deductible for the member.
- 4) Additional Deductibles
 - a. Emergency Room Deductible
 - i. The deductible shall be \$425.00 for each hospital emergency room visit.
 - ii. Effective July 1, 2014, this amount shall increase by \$25.00 for a total emergency room deductible of \$450.00.
 - b. QCHP Network Inpatient Hospital Admission Deductible
 - i. The deductible shall be \$75.00 for each admission to a hospital within the QCHP Network.
 - ii. Effective July 1, 2014, this amount shall increase by \$25.00 for a total deductible of \$100.00.
 - c. Non-QCHP Provider Inpatient Hospital Admission Deductible
 - i. The deductible shall be \$400.00 per admission to a non-QCHP hospital.
 - ii. Effective July 1, 2014, this amount shall increase by \$100.00 for a total deductible of \$500.00.
 - d. Transplant Deductible
 - i. The deductible shall be \$100.00 for a transplant.

B. Plan Coinsurance

- 1) QCHP Network Services
 - a. The Plan shall pay eligible charges, including but not limited to, physician visits, inpatient hospital services, emergency room services, outpatient surgery or procedures, intensive outpatient and partial hospitalization for behavioral health services and laboratory/imaging services provided by a QCHP Network provider at 90% of the negotiated rate.
 - i. Effective July 1, 2014, the payment percentage shall reduce to 85% of the negotiated rate.
 - b. The benefit shall be subject to the applicable deductibles;
 - c. The applicable deductibles and coinsurance amounts shall be applied, dollar-for-dollar, toward the annual QCHP Network out-of-pocket maximum.
 - d. Behavioral health services must be referred by the Behavioral Health Administrator or Personal Support Program and treatment must be provided by licensed providers including psychiatrists, psychologists, Licensed Clinical Social Workers (LCSWs), Licensed Marriage and Family Therapists (LMFTs), Registered Nurse Clinical Nurse Specialists (RNCNSs) and Licensed Clinical Professional Counselors (LCPCs).
 - e. Behavioral health inpatient services must be authorized by the Behavioral Health Administrator.
- 2) Non- QCHP Network Services
 - a. The Plan shall pay eligible charges, including but not limited to, physician visits, inpatient hospital services, emergency room services, outpatient surgery or procedures, intensive outpatient and partial hospitalization for behavioral health services and laboratory/imaging services provided at a Non-QCHP Network facility or by a Non-QCHP Network provider at 60% of the MRC amount.
 - b. The benefit shall be subject to the applicable deductibles.
 - c. The applicable deductibles and coinsurance amounts shall be applied, dollar-for-dollar, toward the annual Non-QCHP Network out-of-pocket maximum.
 - d. Behavioral health services must be referred by the Behavioral Health Administrator or Personal Support Program and treatment must be provided by licensed providers including psychiatrists, psychologists, Licensed Clinical Social Workers (LCSWs), Licensed Marriage and Family Therapists (LMFTs), Registered Nurse Clinical Nurse Specialists (RNCNSs) and Licensed Clinical Professional Counselors (LCPCs).
 - e. Behavioral health inpatient services must be authorized by the Behavioral Health Administrator.

C. Out-of-Pocket Maximums

- 1) Applicable deductibles and coinsurance shall apply, respectively, toward the QCHP Network out-of-pocket maximum or the Non-QCHP Network out-of-pocket maximum. The Plan shall pay 100% of eligible charges for the remainder of the plan year after the out-of-pocket maximum has been met.
- 2) The Individual In-Network QCHP out-of-pocket maximum shall be \$1,500.00.
- 3) The family QCHP Network out-of-pocket maximum shall be two and one-half times the QCHP Network individual out-of-pocket maximum.

- 4) The Non-QCHP Network out-of-pocket maximum shall be \$6,000.00.
- 5) The family Non-QCHP Network out-of-pocket maximum shall be two times the Non-QCHP Network individual out-of-pocket maximum.

D. Medical Out-of-Pocket Maximum Exclusions

The following items do not accumulate toward the medical out-of-pocket maximums:

1. Prescription drug deductibles, co-payments, or coinsurance;
2. Reduction of benefit amounts imposed for failure to notify the Plan's Utilization Management Program administrator;
3. Any charges greater than the MRC amount and any ineligible charges;
4. The portion of the Medicare Part A deductible the member is responsible to pay.

E. Notification and Authorization

- 1) Notification shall be provided to the Utilization Management Administrator by the member prior to receiving any of the following services, including but not limited to:
 - a. Non-emergency hospital, partial hospitalization program, inpatient hospice, skilled care facility admissions and related continued stays;
 - b. All surgical procedures, except those that are performed in a physician's office;
 - c. High-tech imaging services (including but not limited to MRI, PET, and CAT scans);
 - d. Outpatient surgery, in locations other than a physician's office;
 - e. Emergency hospital admission (notification must be provided within 48 hours of an admission);
 - f. Transplant services;
 - g. Hospice Care;
 - h. Skilled Nursing.
- 2) Failure to provide notification to the Utilization Management Administrator shall result in a reduction in reimbursement of the medically necessary charges by \$800.00. Benefits are limited to those covered services that are determined by the Administrator to be medically necessary.

F. Medical Case Management (MCM) Program and Disease Management (DM) Program

- 1) MCM and DM are two Programs designed to assist members or dependents during times of serious or prolonged medical conditions that require complex medical care.
- 2) A case manager may be assigned to the member's or dependent's medical case to ensure appropriate care under the Plan.
- 3) Cases shall be identified and referred to the MCM and/or DM Program by the Utilization Management Administrator and/or Medical Claims Administrator.
- 4) The Utilization Management Administrator shall evaluate the member's or dependent's medical case including treatment setting, level of care and intensity of service. The member or dependent shall be contacted directly by the MCM or

DM Program professional who shall describe the program and make recommendations for settings and/or providers of care. The member will have the option of following or not following the recommendation.

G. Covered Services

1) Preventive Benefits

- a. QCHP shall cover the following preventive physical examinations and immunizations:
 - i. Preventive physical examinations for children in accordance with the recommendations of the U. S. Preventive Services Task Force (USPSTF);
 - ii. Required school physical examinations;
 - iii. Child and adult immunizations in accordance with the recommendations of the Center for Disease Control (CDC) and the Advisory Committee on Immunization Practices (ACIP) guidelines;
 - iv. Adult routine physical examinations in accordance with the recommendations by the USPSTF up to a limit of \$250.00 per exam. Exams will be covered once every three years for adults under age 50 and annually for adults age 50 and over;
 - v. Annual pap smears, including associated office visit charges for women over age 18 or younger if medically appropriate; and
 - vi. Preventive services required pursuant to state or federal law.
- b. For all of the routine physical exams discussed in this section, charges associated with these exams, including but not limited to, physician office charges, laboratory, immunization, imaging, and screening tests, will be covered at the applicable benefit level. The annual QCHP deductible shall not apply to any charges associated with these routine physical examinations. All preventive services received at non-QCHP Network providers are subject to MRC charge review and adjustment.

2) Prescription Drugs

- a. Prescription Plan Year Deductible
 - i. The prescription deductible shall be \$100.00 per member or dependent;
 - ii. This deductible shall apply to all prescriptions covered by the Plan and shall be separate and distinct from all other QCHP deductibles;
 - iii. Effective July 1, 2014, the prescription drug deductible per member or dependent shall increase by \$25.00, resulting in a total prescription deductible per member or dependent of \$125.00.
- b. Co-payments
 - i. Co-payments for a 30-day supply of medication shall be as follows:
 - a. \$10.00 for generic;
 - b. \$30.00 for formulary brand;
 - c. \$60.00 for non-formulary brand.
 - ii. Co-payments for a 60-day supply of medication shall be two times the amount of the applicable 30-day co-payment.
 - iii. If a member or dependent elects a brand name drug where a generic is available, the member or dependent is responsible for the brand co-

- payment plus the difference in cost between the generic and brand name drug.
 - c. Maintenance Medication Program
 - i. Maintenance medications are medications taken for chronic conditions as determined by the Plan.
 - ii. 90-day fills of maintenance medications at mail order, or at a PBM-contracted network retail pharmacy willing to participate in the maintenance medication program on the terms and conditions of the network agreement with the Plan's PBM, shall be available with co-payments equal to two and one-half times the amount of the applicable co-payments for a 30-day supply of medication.
 - iii. After two 30-day fills of maintenance medication obtained at a retail pharmacy, the co-payment of subsequent 30-days fills shall be two times the applicable co-payment for the initial 30-day fill.
 - d. Preferred Drug Step Therapy (PDST) program
 - i. The PDST is a program to be provided by the State's Pharmacy Benefit Manager (PBM) to encourage the use of certain generic and preferred brand drugs that are therapeutically-equivalent to more expensive brand-name drugs.
 - ii. In certain instances, members will be required to try the lower cost generic or preferred brand of pharmaceutical before the Plan would consider coverage of the more expensive brand.
 - e. Brand name drugs for which the generic equivalents have not proven to be effective clinical substitutions based on generally accepted clinical literature and/or medical research shall be treated as generics.
- 3) Physical and Speech Therapy
- a. Inpatient or outpatient therapy shall be covered as described in the State of Illinois Employee Benefits Handbook;
 - b. Services shall be provided by a licensed or certified therapist or physician.
- 4) Chiropractic
- Shall be limited to 30 visits per plan year.
- 5) Transplants
- a. Evaluation shall be covered at a QCHP Network facility. The transplant shall be approved or denied as a result of this evaluation on the basis of whether it is viable and non-experimental;
 - b. All services must be performed at a QCHP Network facility;
- 6) Hospice Care
- Shall be covered as described in the State of Illinois Employee Benefits Handbook.
- 7) Skilled Nursing
- a. Must be authorized by the Utilization Management Administrator. Medicare primary members and dependents are required to notify the Utilization Management Administrator for hospital stays and admission to skilled care facilities;

- b. Care may be rendered at home or in a licensed skilled care facility. The Plan shall pay the lesser of either home health care treatment or care in a licensed skilled care facility within the same geographic region.
- 8) Infertility
Diagnosis and treatment of infertility shall be covered as described in the State of Illinois Employee Benefits Handbook.
- 9) Hospital Bill Audit Benefit
If a member or dependent discovers an error or overcharge on a hospital bill and obtains a corrected bill from the hospital, the member shall be paid 50% of the resulting savings.
- 10) Second Surgical Opinions
The plan will pay 100% of the charges for a second surgical opinion, if required by the Utilization Management Administrator. If the second opinion does not confirm the need for surgery, the plan will pay for a third opinion.

MANAGED CARE HEALTH PLANS (MCHP)

- 1) The State shall continue to offer enrollment in MCHP;
- 2) All eligible services including, but not limited to the following, shall be subject to deductibles, co-payments, coinsurance amounts and out-of-pocket maximums.

A. Co-payments

- 1) Primary Care Physician Office Visit
 - a. The co-payment shall be \$18.00 per Primary Care Physician (PCP) office visit.
 - b. Effective July 1, 2014, this amount shall increase by \$2.00 for a total PCP office visit co-payment of \$20.00.
- 2) Specialist Office Visit
 - a. The co-payment shall be \$25.00 per specialist office visit.
 - b. Effective July 1, 2014, this amount shall increase by \$5.00 for a total specialist office visit co-payment of \$30.00.
- 3) Home Health Care Visit
 - a. The co-payment shall be \$25.00 per home health care visit.
 - b. Effective July 1, 2014, this amount shall increase by \$5.00 for a total home health care visit co-payment of \$30.00.
- 4) Inpatient Admission
 - a. The co-payment shall be \$325.00 per admission to a hospital, hospice, or extended care facility.
 - b. Effective July 1, 2014, this amount shall increase by \$25.00 for a total co-payment of \$350.00 per admission to a hospital, hospice or extended care facility.
- 5) Outpatient Surgery
 - a. The co-payment shall be \$225.00 per outpatient surgery.
 - b. Effective July 1, 2014, this amount shall increase by \$25.00 for a total co-payment of \$250.00 per outpatient surgery.
- 6) Emergency Room

- a. The co-payment shall be \$225.00, or 50%, whichever is less, per emergency room use.
- b. Effective July 1, 2014, this amount shall increase by \$25.00, for a total co-payment of \$250.00 per emergency room.

B. Coinsurance

- 1) The following services shall be covered at 100% after the applicable co-payment:
 - a. Inpatient admission to a hospital, hospice, or skilled care facility;
 - b. Outpatient surgery;
 - c. Emergency room services;
 - d. Primary Care Physician office visits;
 - e. Specialist office visits;
 - f. Home health care visits;
 - g. Professional charges;
 - h. Psychiatric care;
 - i. Prosthetic devices;
 - j. Diagnostic lab and imaging services.
- 2) The following covered services shall be covered at 80%.
 - a. Durable Medical Equipment.

C. Prescription Drugs

- 1) Prescription Plan Year Deductible
 - a. The prescription deductible shall be \$75.00 per member or dependent;
 - b. Effective July 1, 2014, the prescription drug deductible per member or dependent shall increase by \$25.00, resulting in a total prescription deductible per member or dependent of \$100.00.
 - c. This deductible applies to all prescriptions covered by the Plan and shall be separate and distinct from all other MCHP deductibles.
- 2) Co-payments
 - a. Co-payments for a 30-day supply of medication shall be as follows:
 - i. \$8.00 for generic;
 - ii. \$26.00 for formulary brand;
 - iii. \$50.00 for non-formulary brand.
 - b. If a member or dependent elects a brand name drug where a generic is available, the member or dependent is responsible for the brand co-payment plus the difference in cost between the generic and brand name drugs.
- 3) 90-day Supply of Medication
The Plan shall make available a 90-day supply of medication, through certain managed care health plans that are operated on an insured basis. These health plans shall be specified each year during the Benefit Choice Period. Co-payments for the 90-day supply of medication shall be determined by the managed care health plans.
- 4) Brand name drugs for which the generic equivalents have not proven to be effective clinical substitutions based on generally accepted clinical literature and/or medical research shall be treated as generics.

Section 4. DENTAL PLAN COVERAGE

The State may offer a managed care dental plan during the term of this Agreement.

Quality Care Dental Plan (QCDP)

- 1) The State shall continue to offer enrollment in the QCDP.
- 2) Members who choose to receive services from a provider within the QCDP Provider Network shall receive an enhanced benefit.

A. Deductibles

- 1) The deductible shall be \$150.00 per member or dependent per plan year on all covered services except preventive and diagnostic services.
- 2) Effective July 1, 2014, this amount shall increase by \$25.00, resulting in a total plan year dental deductible per member or dependent of \$175.00.

B. Annual and Lifetime Maximums

- 1) The annual maximum benefit for services provided by an in-network provider shall be \$2,500.00 per member or dependent.
- 2) The annual maximum benefit for services provided by an out-of-network provider shall be \$2,000.00 per member or dependent.
- 3) The lifetime maximum benefit for orthodontia services provided by an in-network provider shall be \$2,000.00 per child.
- 4) The lifetime maximum benefit for orthodontia services provided by an out-of-network provider shall be \$1,500.00 per child.

C. Covered Services

- 1) The QCDP shall cover certain preventive, diagnostic, and restorative services as follows:
 - a. Diagnostic and Preventive Services:
 - Initial oral exam;
 - Periodic oral exam;
 - X-rays;
 - Prophylaxis/Fluorides;
 - Sealants.
 - b. Restorative Services:
 - Amalgam fillings, 1 to 4 surfaces;
 - Composite fillings, 1 to 4 surfaces;
 - Crowns;
 - Post and core buildups and crown lengthening;
 - Inlays/Onlays;
 - c. Oral Surgery:
 - Simple extractions (non-surgical) ;
 - Additional single extractions;
 - Surgical extractions;
 - Oral Biopsy;
 - Alveoplasty;
 - Frenectomy;

General anesthesia, including intravenous sedation (where medically necessary);

Conscious sedation (where medically necessary).

- d. Endodontal Services:
 - Root canal - anterior, bicuspid, molar;
 - Pulp capping;
 - Pulpotomy.
 - e. Periodontal Services:
 - Gingivectomy or gingivoplasty;
 - Root planing;
 - Mucogingival surgery;
 - Osseous surgery.
 - f. Fixed and Removable Prosthetics:
 - Full dentures;
 - Partial dentures;
 - Bridges;
 - Implants.
 - g. Orthodontic Services:
 - Comprehensive treatment;
 - Minor Treatment.
- 2) Orthodontic treatment is limited to persons age 18 and under.
 - 3) Orthodontic treatment of deciduous teeth is not covered.

D. Benefit Levels

- 1) The benefit levels for the QCDP shall be determined from a statewide fee schedule equivalent to reasonable and customary charges statewide for all covered services.
- 2) The schedule of maximum benefits shall be reviewed every two years and adjusted based on the most current statewide reasonable and customary data available at that time.
- 3) The benefit for replacement of crowns, bridges and dentures shall be limited to once every five years.

Section 5. VISION PLAN COVERAGE

A vision benefit shall be made available to all members and dependents enrolled in a health plan offered pursuant to the State Employees Group Insurance Act of 1971.

A. Covered Services

Vision services shall be made available as follows:

- 1) Well-care eye examination and, effective July 1, 2014, replacement of lenses, once every plan year;
- 2) Materials benefit once every two plan years. Effective July 1, 2014, frames benefit once every two plan years.

B. Benefits at Network Providers

For services provided by a network provider, the member and/or dependent co-payment shall not exceed the following:

- 1) \$20.00 for the eye exam;
- 2) \$20.00 for lenses;
- 3) \$20.00 for Standard Frames (Standard frames are defined as frames with a \$70.00 average wholesale cost);
- 4) Effective July 1, 2014, the amount of each co-payment for services shall increase by \$5.00 to a co-payment of \$25.00;
- 5) In lieu of standard frames with lenses, there shall be a \$120.00 allowance for the cost of contact lenses.

C. Benefits at Non-Network Providers

For services provided by a non-network provider, reimbursement shall not exceed the following:

- 1) \$30.00 for the eye exam;
- 2) \$50.00 for single vision lenses;
- 3) \$80.00 for bifocals and trifocals;
- 4) \$70.00 for frames;
- 5) In lieu of standard frames with lenses, \$120.00 reimbursement for contact lenses.

Section 6. DISPUTE RESOLUTION

The Parties to this Agreement shall negotiate over the terms of an appeals process that is in conformance with the Affordable Care Act.

Section 7. JOINT LABOR/MANAGEMENT ADVISORY COMMITTEE ON HEALTHCARE BENEFITS

The Joint Labor/Management Advisory Committee on health care benefits shall provide for the development and introduction of value-based benefit design changes for all health plans, with the goal of improving the health of the covered population.

The State agrees to provide a funded position(s) and to budget appropriately to carry out the initiatives of the Committee.

The Committee will be composed of an even number of members, half selected by the State and half selected by AFSCME.

The Committee shall:

- a. Research and make recommendations and decisions within its authority related to the achievement of significant and measurable savings in the cost of employee health care during the terms of this Agreement;
- b. Develop incentives for employees to participate in offered programs including, but not limited to, waivers of co-payments, reductions in co-

insurance and reward programs for participating in various preventive screenings and testing;

- c. Approve changes that will promote better health resulting in lower cost trends and significant cost containment or savings for either the self-insured or the managed care plans;
- d. The State will provide the Committee with data on the healthcare costs on a quarterly basis beginning in May 2013 for the previous quarters' costs for fiscal year 2013 and for each subsequent quarter within 60 days of the close of the previous quarter;
- e. The Committee shall be charged with seeking to identify an additional \$30 million in savings across the State Employees Group Insurance Program for FY15.
- f. The Committee shall submit its recommended modifications, if any, to the plan no later than January 31, 2014 in order to provide for review and implementation for the following fiscal year.

Section 8. WELLNESS

- 1) Flu vaccines for members shall be covered under this program.
- 2) Reimbursement for participation in a smoking cessation program shall be 100% of the cost with an annual maximum of \$200.
- 3) Effective July 1, 2014, reimbursement for participation in a weight loss program shall be 100% of the costs with an annual maximum of \$200.00. This benefit is payable only once every three (3) years.
- 4) The employer will implement value-based benefit design innovations in all health plans effective no later than July 1, 2014, which may include but not be limited to the following disease management programs: a) a prescription co-pay waiver program for individuals with chronic diseases, including diabetes, asthma, hypertension and cardio/vascular disease; b) coverage for prescription smoking cessation medications and behavioral modification counseling for individuals who agree to make an effort to quit tobacco, and c) "reward" programs for health behaviors including, but not limited to, discounts for health club memberships.
- 5) The Joint Labor/Management Advisory Committee on health care benefits may modify this Section with the goal of improving the health of the covered population.

Section 9. TERM LIFE INSURANCE

The State shall provide basic term life insurance equal to 100% of the employee's salary, at premiums to be paid by the State, unless the employee is on a leave of absence as enumerated in the State of Illinois Benefits Handbook. Employees may purchase, subject to medical underwriting requirements of the Life Insurance Administrator, up to eight (8) times their annual salary for optional (member paid) term life insurance and \$10,000.00 in term life insurance for spouses and children.

Section 10. COMMUNICABLE DISEASES

Department of Children and Family Services (DCFS) employees shall have access to TB (tuberculosis) testing and hepatitis B vaccine at no cost to the employee.

The method for administration of this benefit shall be determined jointly by the Department of Central Management Services (DCMS) and DCFS.

Section 11. LAID OFF AND FURLOUGHED EMPLOYEES

- 1) Certified employees on layoff status shall retain health, dental, and vision insurance coverage for a period of one month per year of service, with a minimum of six months and a maximum of twenty-four months following the effective date of the layoff with the Employer paying the full premium, single or family plan as appropriate. Employees who convert to intermittent or part-time status as a result of a layoff shall have their first year of health, dental, vision, and life insurance coverage treated as if they continued to work as a full time employee.
- 2) Employees in furlough status at the Illinois School for the Deaf and Illinois School for the Visually Impaired shall retain health, dental, and vision coverage during scheduled summer breaks with the Employer paying the full premium, single or family plan as appropriate.

Section 12. COMMUTER SAVINGS BENEFIT PROGRAM

The employer shall provide a pre-tax payroll deduction program for transportation expenses in accordance with and to the extent permitted by the Transportation Equity Act for the 21st Century (TEA-21).

Section 13. PAID LEAVE FOR ORGAN TRANSPLANT DONOR

The employer shall grant up to six (6) weeks of leave with pay for living donors of organs including, but not limited to, kidneys, bone marrow, or any other organ that may be transplanted.

Section 14. HEARING BENEFITS

The Employer shall provide benefits for hearing exams and hearing aids, up to a maximum of \$150.00 for audiologist fee(s) and up to a maximum of \$600.00 for hearing aid(s), limited to once every three years.

Section 15. SAME SEX DOMESTIC PARTNERS

A domestic partner of the same sex, enrolled prior to June 11, 2011, shall be considered eligible for coverage under the health, dental and vision plans. The State shall require reasonable proof of the domestic partnership. For purposes of this Section, a domestic partner is defined as an unrelated person of the same sex who has resided in the employee's household and has had a financial and emotional interdependence with the employee, consistent with that of a married couple for a period of not less than one (1) year, and continues to maintain such arrangement consistent with that of a married couple. The benefit shall be administered in accordance with all applicable state and federal laws. The parties recognize and agree that persons who have entered into a civil union in accordance with the Illinois Religious Freedom and Civil Union Act, 750 ILCS 75/1 et seq. (PA 096-1513) and the children of those who have entered into such a civil union shall be entitled to coverage under the health, dental and vision plans as well as to other benefits conferred by the Act. In the event the Illinois Religious Freedom and Civil

Union Act, 750 ILCS 75/1 et seq. (PA 096-1513) is repealed or otherwise rendered invalid, the civil union partner and children who were eligible to receive and who were receiving health, dental and/or vision benefits at the effective date of the repeal or invalidity shall continue to receive such benefits and coverages, and the limiting enrollment date of June 1, 2011, shall be null and void and the provisions of this section of Appendix A shall be made applicable to all same sex domestic partners who meet the definition of domestic partner contained herein.